A. Counterplan Text: Adolescents should be able to make autonomous medical choices if consultations and counseling with a physician or with individuals trained in clinical ethics have occurred and such individual is deemed capable. **The Committee of Bioethics is the solvency advocate:** COMMITTEE ON BIOETHICS, 1993 TO 1994 Arthur Kohrman, MD, Chair Ellen Wright Clayton, MD Joel E. Frader, MD Michael A. Grodin, MD Kathryn L. Moseley, MD Ian H. Porter, MD Virginia M. Wagner, MD <http://www.cirp.org/library/ethics/AAP/#n14> “Informed Consent, Parental Permission, and Assent in Pediatric Practice” PE

**Decision-making involving the health care of older children and adolescents should include**, to the greatest extent feasible, **the assent of the patient as well as the participation of the** parents and **the physician**. Pediatricians should not necessarily treat children as rational, autonomous decision makers, but they should give serious consideration to each patient's developing capacities for participating in decision-making, including rationality and autonomy. If physicians recognize the importance of assent, they empower children to the extent of their capacity.[12](http://www.cirp.org/library/ethics/AAP/#n12) Even in situations in which one should not and does not solicit the agreement or opinion of patients, involving them in discussions about their health care may foster trust and a better physician-patient relationship, and perhaps improve long-term health outcomes. Assent should include at least the following elements: 1) Helping the patient achieve a developmentally appropriate awareness of the nature of his or her condition. 2) Telling the patient what he or she can expect with tests and treatment(s). 3) Making a clinical assessment of the patients understanding of the situation and the factors influencing how he or she is responding (including whether there is inappropriate pressure to accept testing or therapy). 4) Soliciting an expression of the patient's willingness to accept the proposed care. Regarding this final point, we note that no one should solicit a patient's views without intending to weigh them seriously. In situations in which the patient will have to receive medical care despite his or her objection, the patient should be told that fact and should not be deceived. As children develop, they should gradually become the primary guardians of personal health and the primary partners in medical decision-making, assuming responsibility from their parents. Just as is the case with informed consent, the emphasis on obtaining assent should be on the interactive process in which information and values are shared and joint decisions are made. The Academy does not in any way recommend the development of new bureaucratic mechanisms, such as ``assent forms,'' which could never substitute for the relational aspects of consent or assent. THE PATIENT'S REFUSAL TO ASSENT (DISSENT) There are clinical situations in which a persistent refusal to assent (ie, dissent) may be ethically binding.[13](http://www.cirp.org/library/ethics/AAP/#n13) This seems most obvious in the context of research (particularly that which has no potential to directly benefit the patient).[14](http://www.cirp.org/library/ethics/AAP/#n14) A patient's reluctance or refusal to assent should also carry considerable weight when the proposed intervention is not essential to his or her welfare and/or can be deferred without substantial risk. Medical personnel should respect the wishes of patients who withhold or temporarily refuse assent in order to gain a better understanding of their situation or to come to terms with fears or other concerns regarding proposed care. Coercion in diagnosis or treatment is a last resort. 15ETHICAL CONFLICT AND ITS RESOLUTION **Social forces tend to concentrate authority for health care decisions in the hands of physicians and parents and this tendency diminishes the moral status of children**.[12](http://www.cirp.org/library/ethics/AAP/#n12) **Thus, those who care for children need to provide for measures to solicit assent** and to attend to possible abuses of ``raw'' **power over children when ethical conflicts occur.** This is particularly important regarding the initiation, withholding, or withdrawing of life-sustaining treatment.[16,17](http://www.cirp.org/library/ethics/AAP/#n16) Examples **of mechanisms to resolve ethical conflicts include additional medical consultation(s);** **short-term counseling or psychiatric consultation** for patient and/or family; ``case management'' or similar multidisciplinary conference(s); **and/or consultation with individuals trained in clinical ethics or a hospital-based ethics committee**. In rare cases of refractory disagreement, formal legal adjudication may be necessary. LEGAL EMANCIPATION AND INFORMED CONSENT The traditional notion of informed consent clearly applies to patients who have reached the legal age of majority, except when the patient has been determined to be incompetent. In addition, laws designate two settings in which minors have sole authority to make health care decisions.[11](http://www.cirp.org/library/ethics/AAP/#n11) First, certain minors are deemed ``emancipated'' and treated as adults for all purposes. Definitions of the emancipated minor include those who are: 1) self-supporting and/or not living at home; 2) married; 3) pregnant or a parent; 4) in the military; or 5) declared to be emancipated by a court. Second, many states give decision-making authority (without the need for parental involvement) to some minors who are otherwise unemancipated but who have decision-making capacity (``mature minors'') or who are seeking treatment for certain medical conditions, such as sexually transmitted diseases, pregnancy, and drug or alcohol abuse.[18](http://www.cirp.org/library/ethics/AAP/#n17) The situations in which minors are deemed to be totally or partially emancipated are defined by statute and case law and may vary from state to state.[19](http://www.cirp.org/library/ethics/AAP/#n19) Legal emancipation recognizes a special status (eg, independent living) or serious public and/or individual health problems that might not otherwise receive appropriate attention (eg, sexually transmitted disease).

B. Competition-

1) in the aff world adolescents always have the ability to make autonomous medical choices in my world it only happens after consultation on a case to case basis.

2) The consultations wouldn’t matter if they granted all adolescents the ability to make autonomous medical choices right after thus you would lose all benefits of the CP.

C. Net benefits and Solvency:

Adolescents do not have the same rational capacity as adults; they need time to build their experiences. **Pustilnik et Al:** AMANDA C. PUSTILNIK is an Associate Professor of Law at the University of Maryland School of Law, and LESLIE MELTZER HENRYJD, MSc, is a core faculty member at the Johns Hopkins Berman Institute of Bioethics “Introduction: Adolescent Medical Decision Making and the law of the horse” 2012 PE

**Executive function and emotional responses are not just less developed or different in teens**: These two capacities are also **[but] less closely linked** than in the typical adult brain.3' **As a result, a teen may intellectually understand an issue** **and emotionally have a response** to that issue, **but those two processes may occur nearly in parallel rather than in dialogue**.32 **This implicates decision making, because decisions are not simply**, or even primarily, **rational**: Emotional and executive functions must work together to bring about almost any kind ofdecision.33 For the pfc to receive and then inhibit impulses arising from the brain's limbic regions, these brain regions must be connected to each other via nerve fibers**. In adults with normal impulse control, long, thick "tracts" of nerve fibers connect the prefrontal cortex with key limbic areas**. 34 Research correlates the density and extent (literally the length) of the fibers tracts with impulse; several experiments have succeeded in using the strength of these connections in predicting self-control in laboratory tasks.35 **Adults have these neural connections because they developed them during adolescence; adolescents, who may have highly developed verbal and intellectual capacities, are still in the process of developing these inhibitory and evaluative connections between intellect and drive or emotion**. 36 If people were cars, it would be as if we came out of the factory with all the acceleration-all the drive, or drives-we will ever have but with our brake cables only weakly connected. For the brake cables to connect more strongly over time, the precarious car must take to the road and practice braking.37 The brain develops its executive control, inhibitory strength, and synthesis of emotion and reason through the marriage of time and practice. This is because mature decision making arises from ontogeny and experience. **Adolescents thus need not only time but also the right kinds of experiences**, which might include patterning and modeling on good mentors, taking risks and making mistakes, engaging in meaningful reflection on one's own experiences and those of others, and participating in formal and informal education that cultivates moral and humane virtues. The articles in this Issue explore ways in which various legal and ethical rules can, and in some cases already do, balance the interests of protecting adolescents- and others-from their potentially poor decisions while allowing them enough autonomy to gain the life experiences they need to become competent adults. Having provided overviews of the legal and ethical regimes relating to adolescent decision making, and the key features that distinguish the brain structures and functions of adolescents from those of adults, this Introduction briefly describes the articles that follow in this Issue.

# CP solves only if Adolescents are determined rational will they be able to make an autonomous medical choice. Tunizi: MARC TUNZI, M.D., Natividad Medical Center, Salinas, California “Can the Patient Decide? Evaluating Patient Capacity in Practice” 2001 <http://www.aafp.org/afp/2001/0715/p299.html> PE

**Primary care physicians are qualified to perform capacity assessments**. There are several reasons why a patient's primary care physician may be the best professional to assess capacity[1](http://www.aafp.org/afp/2001/0715/p299.html#afp20010715p299-b1),[7](http://www.aafp.org/afp/2001/0715/p299.html#afp20010715p299-b7): (**1) the primary physician already knows the patient's medical circumstances** and the question to be decided; (**2) the primary physician may have the best opportunity to know the patient's** and their family's **personal values** and cultural and religious views; (3**) the primary physician has the benefit of history**, so that the assessment is not a one-visit snapshot of a patient but is a longitudinal and more thorough assessment based on multiple interactions; **and (4) the primary physician, because of an ongoing medical relationship with the patient**, is in the best position to reevaluate capacity in the future.Psychiatrists are more expert in evaluating patients with severe mental illness and may be legally required, in some locales, to assess patients referred to the courts. However, research comparing their judgments to those of other physicians shows that they are no better at assessing capacity in practice.[13](http://www.aafp.org/afp/2001/0715/p299.html#afp20010715p299-b13)At the same time, however, because psychiatrists perform capacity evaluations frequently, primary care physicians should feel comfortable consulting them in difficult cases. A bioethics panel may also help clarify or delineate the issues that need to be addressed with a specific patient. Follow-up of Illustrative Cases CASE 1 The 54-year-old woman with schizophrenia and multiple medical problems reported that she was not now hearing voices nor was she exhibiting any other psychotic symptoms. She had been very stable on her psychiatric medications for several months. The patient understood her medical situation, appreciated the consequences of care options, analyzed logically the information she was given and was able to express a clear choice. She was judged to have capacity. After learning selfcatheterization, demonstrating knowledge of her medication regimen and agreeing to home health nursing care, she returned home and returned for follow-up visits as directed. CASE 2 The 78-year-old man with metastatic cancer of unknown primary understood his medical condition and was able to express his choice, but he could not appreciate the fact that the biopsy would probably not affect treatment or outcome and he could not analyze the information given him. Even when he was lucid, he was convinced “the test” would cure him, despite repeated explanations. He was judged not to have capacity. He had a durable power-of-attorney for health care naming his wife as his agent, and, after further discussion, she declined the biopsy. He died several weeks later without a tissue diagnosis but with full palliative care. Final Comment **Physicians assess the decision-making capacity of their patients at every clinical encounter**. **Patients requiring careful assessment can be easily identified using standardized evaluations** performed by means of a directed clinical interview or the use of a formal assessment tool such as the ACE[3](http://www.aafp.org/afp/2001/0715/p299.html#afp20010715p299-b3),[12](http://www.aafp.org/afp/2001/0715/p299.html#afp20010715p299-b12) or the MacCAT.[1](http://www.aafp.org/afp/2001/0715/p299.html#afp20010715p299-b1) **If the patient lacks the capacity for decisionmaking, a determination of surrogacy will be necessary**. In the best-case scenario, the patient may have previously appointed an agent; in the worst-case scenario, the court may need to become involved. (The discussion of surrogacy is too broad for this article, but it has been well-covered elsewhere.)[4](http://www.aafp.org/afp/2001/0715/p299.html#afp20010715p299-b4),[14](http://www.aafp.org/afp/2001/0715/p299.html#afp20010715p299-b14) If the patient does not have an advance directive or health care proxy, the surrogate will need to make decisions based on principles of “substituted judgment”(what the patient would have decided) or “best interest” (what the surrogate judges to be best for the patient).